1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG269 8-22-60 et

9022

CERTIFICATE OF DEATH

08996

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: N.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton RD # 1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lempi — Middle — Last AITTO
4. DATE OF DEATH: Month 8 — Day 11 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 15, 1899
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gustav Kiikka
14. MOTHER'S MAIDEN NAME: No record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: George Aitto — Address: Elkton, Md. RD#1 Box 260

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA, head, pancreas — INTERVAL BETWEEN ONSET AND DEATH: 2 Months
157X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/7, 1960 to 8/11, 1960 that I last saw the deceased alive on 8/10, 1960, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Fischer M.D. — ADDRESS (Street, city or town, state): 162 W MAIN. ST. — DATE SIGNED: 8/11/60
PHYSICIAN'S NAME (Type): John A. Fischer — ELKTON, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Aug. 15, 1960
22c. NAME OF CEMETERY OR CREMATORY: Silverbrook
22d. LOCATION (City, town, or county) (State): Wilmington, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: R.T. Jones — ADDRESS: Newark, Del.
24a. REC'D BY REGISTRAR: DATE AUG 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: If certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G271 9-14-60 et

08997

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ~~Rising Sun~~, Colora
c. LENGTH OF STAY IN 1b: several yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: ; Last: Alt
4. DATE OF DEATH: Month: 8; Day: 30; Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-25-1930
9. AGE (In years last birthday): 28 29 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Pony Farm
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Arthur J. Alt
14. MOTHER'S MAIDEN NAME: Mabel Lindsay
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): Jan. 1951 - Jan. 1953
16. SOCIAL SECURITY NO.: 393-28-9402
17. INFORMANT: Mrs. William Alt. Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rifle shot in left breast
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Placed rifle against chair and chest and hit trigger with stick
20c. TIME OF INJURY: 8.45 Hour a.m. p.m. Month, Day, Year: 8 30 1960
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm
20f. (City or town): Colora (County): Cecil (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): R.C. Dodson
Address (Street, city, town, or county):
DATE SIGNED: 8-30-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 3 1960
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham
22d. LOCATION (City, town, or country): Near Colora (State): Md.

23. FUNERAL DIRECTOR: William J. Johnston ADDRESS: Oxford Pa.
24a. REC'D BY REGISTRAR: SEP 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krouse

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9043 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08998

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark, R.D.12
c. LENGTH OF STAY IN 1b: 46 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark R.D.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Benjamin Middle: Franklin Last: Badders

4. DATE OF DEATH Month: 8 Day: 10 Year: 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-11-1876
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Badders
14. MOTHER'S MAIDEN NAME: Elizabeth Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ——
17. INFORMANT Address: Mrs. Benjamin F. Badders, New Ark, Del. R.D.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO (b) Chronic Nephritis
DUE TO (c)

592

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 8-11-60

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/13/60
22c. NAME OF CEMETERY OR CREMATORY: Head of Christiana Cem.
22d. LOCATION (City, town, or county) (State): Newark Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Albert J. McCrery per
ADDRESS: 2700 Washington St., Albert J. McCrery, Wilmington, Delaware
24a. REC'D BY REGISTRAR DATE: AUG 16 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9023

CERTIFICATE OF DEATH

08999

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 15 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle C. Last COOKE, SR.

4. DATE OF DEATH: Month Aug. Day 9, Year 1960

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 30, 1905

9. AGE (In years lost birthday): 55 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: duPont Company

11. BIRTHPLACE (State or foreign country): Brooklyn, N. Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Merle Cooke

14. MOTHER'S MAIDEN NAME: Elizabeth B. Cortelyou

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 092-01-7441

INFORMANT: Mrs. John C. Cooke, Sr. Address: nr. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pentonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Gangrene of large bowel & perforation — 2 days

DUE TO (c):

576X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Anterior Coronary Thrombosis 1 day — Chronic Nephritis many years

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 19 60 to Aug 9, 19 60, that I last saw the deceased alive on Aug 6, 19 60, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V. Davis M.D.

ADDRESS (Street, city or town, state): CHESAPEAKE CITY MD

DATE SIGNED: 8/10/60

PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

22b. DATE THEREOF: 8-12-60

22c. NAME OF CEMETERY OR CREMATORY: SILVERBROOK CREMATORY

22d. LOCATION (City, town, or county) (State): Wilmington, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME

ADDRESS: Donald M. Lee Elkton, Md.

24a. REC'D BY REGISTRAR: DATE AUG 11 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9044

Reg. Dist. No. 09000

M

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 4713 Fairfield Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print) First: Joseph Middle: J. Last: Cunningham
4. DATE OF DEATH Month: 8 Day: 20 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-4-16
9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): S.Carolina
12. CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: Joseph John Cunningham
14. MOTHER'S MAIDEN NAME: Stella Roberts
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-11
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Ann Cunningham, wife, 7224 Lee Street. Address Columbia, S. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated Body Resulting From Being Hit By Train. Immed. — INTERVAL BETWEEN ONSET AND DEATH

979X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: 3:50 ~~a.m.~~ p.m. Month, Day, Year: 8 20 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): PRR Tracks
20f. (City or town) Perryville (County) Cecil (State) Maryland

2

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 8-20-60

EXAMINER'S NAME (Type) R.C. DODSON

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 8/25/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE AUG 31 '60
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible] TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

M

065

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9024 **CERTIFICATE OF DEATH** 09001

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 7 wks

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Childs (R.D.)

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Virdela — Middle: P. — Last: Davis

4. DATE OF DEATH: Month: Aug — Day: 18 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-11-84

9. AGE (In years lost birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram Pleasanton

14. MOTHER'S MAIDEN NAME: Elizabeth George

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

INFORMANT: Alice Marie Husfelt — Address: Childs, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, probably primary in the
DUE TO
(b) pancreas, with metastases
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

157 X

INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 28, 1960, to Aug 18, 1960, that I last saw the deceased alive on Aug 18, 1960, and that death occurred at 1:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Tillman D. Johnson M.D. — ADDRESS (Street, city or town, state): 123 Sincerity Ave — DATE SIGNED:

PHYSICIAN'S NAME (Type): Tillman D. Johnson — Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/21/60

22c. NAME OF CEMETERY OR CREMATORY: Forest Presbyterian Cem.

22d. LOCATION (City, town, or county) (State): Middletown, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland

24a. RECD. BY REGISTRAR DATE: AUG 23 60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9045 — CERTIFICATE OF DEATH — 09002

Item 7 Film 6269 8-25-60 et

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ unknown

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle M. — Last DAVIS

4. DATE OF DEATH: Month August — Day 9 — Year 19 60

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-15-95
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James F. Davis
14. MOTHER'S MAIDEN NAME: Bell Redd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 222-03-3668
17. INFORMANT: Harry N. Davis, brother, 5820 Addison St., Philadelphia, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) Immediate cause: Bronchopneumonia right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.: Carcinoma of the stomach with widespread — unknown
DUE TO
(c) metastasis to abdominal cavity

151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from August 6, 1960, to August 9, 1960 and that death occurred at 3:15pm from the causes and on the date stated above.

22a. SIGNATURE: J. L. Garey M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-10-60
22c. PHYSICIAN'S NAME (Type): J. L. GAREY, Clinical Pathologist,
22d. ADDRESS: V.A. Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 13, 1960
23c. NAME OF CEMETERY OR CREMATORY: Unknown
23d. LOCATION (City, town, or county) (State): Cecilton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Cecilton, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Edward Fellows

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9025 Item 1 FilmG269 8-18-60 et

09003
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 9yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ----

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D.# 1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: A. Clark; Middle: C.; Last: Dutton
4. DATE OF DEATH: Month: August; Day: 8; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Textile
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Dutton
14. MOTHER'S MAIDEN NAME: Arabella Prettyman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 221-07-3396
17. INFORMANT: Preston E. Dutton, Address: Claymont, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. L. Dorsey M.D.
EXAMINER'S NAME (Type): R. L. Dorsey
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-11-60
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cem.
22d. LOCATION (City, town, or county) (State): Elkton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks, ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: AUG 12 '60
24b. REGISTRAR'S SIGNATURE: Esther L. Mears

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9026

CERTIFICATE OF DEATH

09004
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 35 YR
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 136 E Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle Last HARRIS
4. DATE OF DEATH: Month AUG. Day 25 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 23 1905
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JULUS HARRIS
14. MOTHER'S MAIDEN NAME: NO IFOR.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: MRS. SAMUEL HARRIS Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: (1) hour
DUE TO
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Prostatectomy — 2 days
DUE TO
(c) Chr. Myocardial Disease — 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Johnson M.D. ADDRESS (Street, city or town, state): 245 E. High St, Elkton, Md DATE SIGNED: 8/25/60
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: AUG 26, 1960
22c. NAME OF CEMETERY OR CREMATORY: MOUNT SHARON
22d. LOCATION (City, town, or county) (State): DELAWARE COUNTY PA
23. FUNERAL DIRECTOR'S SIGNATURE: Pepper Funeral Home ADDRESS: Donald M. Pepper Elkton MD
24a. REC'D BY REGISTRAR DATE: AUG 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9027

CERTIFICATE OF DEATH

09005

Reg. Dist. No.

M

065

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 1 mo.14 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

d. STREET ADDRESS: Main St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Chester Last: Harvey

4. DATE OF DEATH Month: August Day: 14 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 2, 1880

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Veterans Administrn.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Harvey

14. MOTHER'S MAIDEN NAME: Elizabeth A. Friday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 212-01-5073

INFORMANT: Mrs. Allie M. Harvey, Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

450.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of Prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/25, 1960, to 8/14, 1960, that I last saw the deceased alive on 8/14, 1960, and that death occurred at 7:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. ADDRESS (Street, city or town, state): North East, Md. DATE SIGNED: 8/14/60

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial **22b.** DATE THEREOF: 8-17-60 **22c.** NAME OF CEMETERY OR CREMATORY: North East Methodist Cem. **22d.** LOCATION (City, town, or county) (State): North East Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant ADDRESS: North East, Maryland.

24a. REC'D BY REGISTRAR DATE: AUG 18 '60 **24b.** REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9028

CERTIFICATE OF DEATH

09006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 18 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

d. STREET ADDRESS: X

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: P Last: Holden

4. DATE OF DEATH Month: August Day: 21 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 6, 1878

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Farming Farm Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William W. Holden

14. MOTHER'S MAIDEN NAME: Talitha Mahoney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 214-36-8733

INFORMANT: Mr. George Holden, Address: North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right lowe r lobe — 1 month

490X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular diseae and emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: July 27 Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from August 21, 1960 to August 21, 1960, that I last saw the deceased alive on August 21, 1960, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D. ADDRESS (Street, city or town, state): 233 E. Main Street DATE SIGNED: 8/21/60

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-24-60

22c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

22d. LOCATION (City, town, or county) (State): North East, Cecil Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant ADDRESS: North East, Maryland.

24a. REC'D BY REGISTRAR DATE: AUG 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9029

CERTIFICATE OF DEATH

09007

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 13 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle STEPHEN — Last HOTRA

4. DATE OF DEATH: Month Aug. — Day 15, — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 15, 1960

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 13 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hotra

14. MOTHER'S MAIDEN NAME: Mildred Maksyn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT: Mr. John Hotra, Address: Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Lung Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

760.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intra Cranial Hemorrhage — Prematurity

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 15, 1960, to Aug. 15, 1960, that I last saw the deceased alive on Aug. 15, 1960, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V. Davis M.D. — ADDRESS (Street, city or town, state): Chesapeake City Md. — DATE SIGNED: 8/16/60

PHYSICIAN'S NAME (Type): HENRY V. DAVIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-17-60

22c. NAME OF CEMETERY OR CREMATORY: St. Roses Cemetery

22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Donald L. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2065 30 1X V4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG270 9-6-60 et

9030

CERTIFICATE OF DEATH

09008

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: Rd #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: ; Last: Howell

4. DATE OF DEATH: Month: Aug.; Day: 25; Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1/16/1885

9. AGE (In years lost birthday): 75 yrs. 7/16

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Howell

14. MOTHER'S MAIDEN NAME: Minnie Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Inez D. Trent — Address: Rd #1 Elkton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anemia Malnutrition
DUE TO (b): Cancer of Lung & Metastasis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163

INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1st, 1960, to Aug 25, 1960 that I last saw the deceased alive on Aug 25, 1960, and that death occurred at 4:45 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph G. Lanzi M.D. — ADDRESS (Street, city or town, state): 205 W Main St — DATE SIGNED: 8/25/60

PHYSICIAN'S NAME (Type): Joseph G. Lanzi Elkton Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-27-60

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pippin Funeral Home Inc. Elkton, Md.

24a. REC'D BY REGISTRAR DATE AUG 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9031

CERTIFICATE OF DEATH

Reg. Dist. No. 09009

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 3 WKS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 399 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara Middle: B. Last: Hutchins
4. DATE OF DEATH: Month: Aug. Day: 27 Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1867
9. AGE (In years last birthday): 93 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elias James
14. MOTHER'S MAIDEN NAME: Sinah Jester
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 222-07-6872
17. INFORMANT: Mrs. Nolan Hutchins, Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cerebrovascular accident with hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease; hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 16, 1960, to Aug. 27, 1960, that I last saw the deceased alive on Aug. 27, 1960, and that death occurred at 10:30 2M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr M.D. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 8/27/60
PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR., M.D. Elkton Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/60
22c. NAME OF CEMETERY OR CREMATORY: Lake Side Cem.
22d. LOCATION (City, town, or county) (State): Dover Del.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter du Bois, Jr.
ADDRESS: ELKTON, Md.
24a. REC'D BY REGISTRAR DATE AUG 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9032

Reg. Dist. No. 09010

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, Md.
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, Md. R.D. #1
d. STREET ADDRESS: R.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Columbus; Middle: Lee; Last: Jackson

4. DATE OF DEATH: Month 8/ Day 17/ Year 1960

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/28/1960

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months 1 Days 20
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elkton, Maryland

12. CITIZEN OF WHAT COUNTRY?: —

13. FATHER'S NAME: Clarence Andrew Jackson

14. MOTHER'S MAIDEN NAME: Martha Lean Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Clarence Andrew Jackson Address: R D #1 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dehydration and malaurition
773.0
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/17/60

EXAMINER'S NAME (Type): R. C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG 19, 1960
22c. NAME OF CEMETERY OR CREMATORY: NORTH EAST CEMETERY
22d. LOCATION (City, town, or county) (State): NORTH EAST, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME, Donald M. Dee
ADDRESS: ELKTON Md.
24a. REC'D BY REGISTRAR DATE: AUG 23 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

2065202XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9033 **CERTIFICATE OF DEATH** 09011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 1 Dickie Biddle Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: William Middle: Henry Last: Keithley
4. DATE OF DEATH: Month: Aug Day: 23 Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-1-85
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Elk Neck Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Keithley
14. MOTHER'S MAIDEN NAME: Susan Heath
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: W. Robert Keithley Address: Elkton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease C — INTERVAL BETWEEN ONSET AND DEATH: 5 mos.
420.0
DUE TO (b) Decompensation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis, Generallized — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1960, to Aug 23, 1960, that I last saw the deceased alive on Aug 23, 1960, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Tillman D Johnson M.D. ADDRESS (Street, city or town, state): 123 Sincerity Ave DATE SIGNED:
PHYSICIAN'S NAME (Type): Tillman D Johnson Elkton, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/26/60
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9034 **CERTIFICATE OF DEATH** 09012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 40 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Un 430 North Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton 21

d. STREET ADDRESS: 430 North Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: W. Last: Kincaid

4. DATE OF DEATH Month: 8 Day: 14 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 15, 1894

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lineman

10b. KIND OF BUSINESS OR INDUSTRY: Conowingo Power Company

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Kincaid

14. MOTHER'S MAIDEN NAME: Mary Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-8062

INFORMANT: William P. Kincaid, Address: Elkton, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — 1 hr

420.0

DUE TO (b) Arteriosclerotic Heart disease — 9 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hemorrhage, Secondary To duodenal ulcer.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/24, 1960, to 8/14, 1960, that I last saw the deceased alive on 8/14, 1960, and that death occurred at 2:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Fischer M.D. — ADDRESS (Street, city or town, state): 162 W MAIN ST. — DATE SIGNED: 8/16/60

PHYSICIAN'S NAME (Type): John A. Fischer — ELKTON, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/17/60

22c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception

22d. LOCATION (City, town, or county) (State): Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9046 — Reg. Dist. No. 09013

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City, R.CD Visting
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa. — b. COUNTY: Bucks
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Litiz R.D.1
d. STREET ADDRESS: 75X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: L — Last: Lehr

4. DATE OF DEATH: Month: 8 — Day: 7 — Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 8-21-1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station
10b. KIND OF BUSINESS OR INDUSTRY: Sales
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Purman Lehr
14. MOTHER'S MAIDEN NAME: Hattie Kutz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 196-05-6081
17. INFORMANT — Address: Mrs. Charles L Lehr. Litiz, R.D.1. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowned — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):

929.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned trying to rescue another man
20c. TIME OF INJURY: Hour: 11 a. m. p. m. — Month, Day, Year: 8 7 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Elk River
20f. (City or town): Port Herman — (County): Cecil — (State): Md.

21. I certify that I taak charge af the remains described abave, held an Autapsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R C Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-7-60
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 10,1960
22c. NAME OF CEMETERY OR CREMATORY: Mellingers Cemetery
22d. LOCATION (City, town, or county) (State): Schoeneck, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 11 '60
24b. REGISTRAR'S SIGNATURE: Chelsea L. Mears

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9035

CERTIFICATE OF DEATH

Reg. Dist. No. 09014

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ELKTON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural HAVRE DE GRACE
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First REBECCA Middle JANE Last MACKLEM

4. DATE OF DEATH: Month AUG Day 11 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8 MAY 1872
9. AGE (In years lost birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMER
11. BIRTHPLACE (State or foreign country): DEL
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN M. MACKLEM
14. MOTHER'S MAIDEN NAME: ELIZABETH DAVIES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-36-4983
INFORMANT: Miss Sarah L. Macklem — Address: Havre de Grace RD.#2 MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b) Generalized arteriosclerosis — Unknown
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33 IX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 4, 1960, to August 11, 1960, that I last saw the deceased alive on August 11, 1960, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Andrews, Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main St. — DATE SIGNED: Aug 11, 1960
PHYSICIAN'S NAME (Type): S. RALPH ANDREWS JR. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 14 AUG. 1960
22c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.
22d. LOCATION (City, town, or county) (State): HARFORD Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: H. Madison Mitchell — ADDRESS: 123 So. Washington Havre de Grace Md.
24a. REC'D BY REGISTRAR: DATE AUG 15 '60
24b. REGISTRAR'S SIGNATURE: Chelsea S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9036

CERTIFICATE OF DEATH

Reg. Dist. No. 09015

M

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

065

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: — Last: Manlove

4. DATE OF DEATH: Month: August — Day: 14, — Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 29, 1898
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Teaching
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: John L. Manlove
14. MOTHER'S MAIDEN NAME: Mary Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Clara Burke, Address: Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Intracranial Hemorrhage — 5 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1933, to August 14, 1960, that I last saw the deceased alive on Aug 14, 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): CHESAPEAKE CITY MD
DATE SIGNED: 8/15/60
PHYSICIAN'S NAME (Type): HENRY W. DAVIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 17, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery
22d. LOCATION (City, town, or county) (State): Cecilton Cecil Co; Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows, ADDRESS: Millington, Md.
24a. REC'D BY REGISTRAR DATE AUG 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9047 Item 16 FilmG268 8-10-60 et 09016 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East. R.D.
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East R.D.1.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Arthur Middle Last Maus
4. DATE OF DEATH: Month 8 Day 2 Year 19 60
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-3-1910
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Projection Op. Equip
10b. KIND OF BUSINESS OR INDUSTRY: V.A.Admistration
11. BIRTHPLACE (State or foreign country): New York,
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Phillip Maus
14. MOTHER'S MAIDEN NAME: Ida Ziesig
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO. (Gov. employee): None
17. INFORMANT: V.A.Administration, Perry Point, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mutilated Body
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Squatted xdown on P.R.R. Tracks in front of train
20c. TIME OF INJURY: Hour 10.40 a. m. p. m. Month, Day, Year 8 2 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): P.R.R.Tracks
20f. (City or town) North East, R.D.1 (County) Cecil (State) Md.

21. I certify that I taak charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): R.C.Dodson
DATE SIGNED: 8-3-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-4-1960
22c. NAME OF CEMETERY OR CREMATORY: Hopewell Methodist
22d. LOCATION (City, town, or county) Port Deposit R.D. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant North East Md ADDRESS
24a. REC'D BY REGISTRAR: DATE AUG 5 '60
24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9037

CERTIFICATE OF DEATH

09017

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D. 5
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Charles — Last: Maxwell

4. DATE OF DEATH: Month: August — Day: 1 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 29, 1909

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Chemical

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry Maxwell

14. MOTHER'S MAIDEN NAME: Mary Sayers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W W 2

16. SOCIAL SECURITY NO.: 229-01-6043

17. INFORMANT: Mrs. Rhoda M. Maxwell, Elkton, Md.
Address: R.D.5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1hr.
420.1
DUE TO (b) Myocarditis & failure due to — 1yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Passive coronary thrombosis 1year ago.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 12-19, 1959, to 8-1, 1960, that (I) (we) last saw the deceased alive on 7-30, 1960, and that death occurred at 2 A.M., from the causes and on the date stated above.

22a. SIGNATURE: G. H. Richards Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/2/60

22c. PHYSICIAN'S NAME (Type): G. H. Richards, Jr.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/4/60

23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial

23d. LOCATION (City, town, or county) (State): Park, Elkton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR: DATE AUG 8 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9048 — Reg. Dist. No. 09018

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sea Mark Marino

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, R. D. 1
d. STREET ADDRESS: 1 Elkton, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: AMOS — Middle: — Last: MULLINS

4. DATE OF DEATH: Month: August — Day: 19 — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: April 1, 1899
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Guard
10b. KIND OF BUSINESS OR INDUSTRY: Veterans Adm. Hosp., Perry Point Maryland
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ----
14. MOTHER'S MAIDEN NAME: Nancy ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.War 2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Irene Mullins, R. D. 1, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:
929.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell into the North East River
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: 8/ 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): North East River
20f. (City or town) (County) (State): Charlestown, Cecil, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. D. Dodson M.D.
EXAMINER'S NAME (Type): R. D. Dodson, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 21, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/25/60
22c. NAME OF CEMETERY OR CREMATORY: North East Methodist
22d. LOCATION (City, town, or county) (State): Cemetery, North East, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: AUG 29 '60
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

Item 20 Film271
9-29-60 ams

9038

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Item 5 Film6271 9-19-60 et

Reg. Dist. No. 10169

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Childs, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Denny — Last: Pearson

4. DATE OF DEATH: Month: August — Day: 29 — Year: 1960

5. SEX: Female ~~Male~~

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 22, 1880

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank J. Denny

14. MOTHER'S MAIDEN NAME: Lydia A. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mr. Edwin O. Pearson — Address: Childs, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FRACTURED NECK OF FEMUR — INTERVAL BETWEEN ONSET AND DEATH: AUG 8-1960
904.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lived alone, was found by neighbor unable to walk

20c. TIME OF INJURY: Hour a. m. p. m. — Month: 8 — Day — Year: 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Childs — (County): Cecil — (State): Md

21. I certify that I attended the deceased from Aug 9, 1960, to Aug 29, 1960, that I last saw the deceased alive on Aug 29, 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry P. Davis M.D. — ADDRESS (Street, city or town, state): Chesapeake City — DATE SIGNED: 8/30/60

PHYSICIAN'S NAME (Type): HENRY P. DAVIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 2, 1960

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county): Elkton, (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9049

CERTIFICATE OF DEATH

09020

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: Morgan Last: Pollard

4. DATE OF DEATH: Month: Aug. Day: 10 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert T. Morgan
14. MOTHER'S MAIDEN NAME: Mary W. Cochran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary E. Stipa Address: Cecilton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Cecum with wide spread metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 months.
153.0
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 3, 1960, 19____, to Aug 10, 1960, 19____, that I last saw the deceased alive on Aug 10 1960, 19____, and that death occurred at 3:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 12 Aug 60

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D. Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 13, 1960
22c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery
22d. LOCATION (City, town, or county) (State): Galena Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Gilbert Millington Md.
ADDRESS:
24a. REC'D BY REGISTRAR DATE: AUG 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9050

CERTIFICATE OF DEATH

09021

M

050

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 323 Southamptin Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1516-2

3. NAME OF DECEASED (Type or print): First: Albert E. Middle: Last: ROOF
4. DATE OF DEATH: Month: August Day: 21 Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-9-96
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Chester, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HOSEA ROOF
14. MOTHER'S MAIDEN NAME: WILLIE J McCANNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: 247-07-0965
17. INFORMANT: Lillian Roof (W) Address: Silver Springs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA Chexia and Anemia
DUE TO (b) Cancer of Prostate Gland — 2Yrs6Mo
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/14/60, 19__, to 8/21/60, 19__, and that death occurred at 6:45A a. m. from the causes and on the date stated above.

22a. SIGNATURE: Stephen A. Hegedus, M.D. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/21/60
22c. PHYSICIAN'S NAME (Type): Stephen A. Hegedus M.D.
22d. ADDRESS: Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-24-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chandler Co
ADDRESS: Riverdale Md
25a. REC'D BY REGISTRAR DATE: AUG 24 60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9051 Item 9 Film 6270 9-6-60 et

09022

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4mos.8days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, 1224.2
d. STREET ADDRESS: 653 Bourbon St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

050

3. NAME OF DECEASED (Type or print): First BENJAMIN Middle F. Last SINGLETON

4. DATE OF DEATH: Month August Day 28 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 12-11-93
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civilian Gunner
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (State or foreign country): Havre de Grace, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Steve Singleton(dec)
14. MOTHER'S MAIDEN NAME: Priscilla Sampson(dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes, give war or dates of service): WWl
16. SOCIAL SECURITY NO.: 220-22-0987
17. INFORMANT: Mrs. Elsie S. Singleton. Address: 653 Bourbon St., Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 4mos. 8days
DUE TO (b)
DUE TO (c)

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X (this hospital) attended the deceased from 4-20, 1960, to 8-28-, 1960, ~~(we) (last saw the deceased alive on xxxxxxxxxxxxxxxx 19xx~~, and that death occurred at 8:25 PM from the causes and on the date stated above.

22a. SIGNATURE: E. S. Ells, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): E. S. ELLS, M.D., Acting Director. Professional Services
22d. ADDRESS: VAH, Perry Point, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 8-31-60 8-28-60
23c. NAME OF CEMETERY OR CREMATORY: Rock Run Cem.
23d. LOCATION (City, town, or county) (State): Harford Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell
ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE SEP 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9052

CERTIFICATE OF DEATH

09023
Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 30yrs.8mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1621 Dartford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HOMER; Middle: L.; Last: SMITH

4. DATE OF DEATH: Month: August; Day: 30; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-14-95

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Smith

14. MOTHER'S MAIDEN NAME: Not available from records

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

INFORMANT: Nannie Smith, wife, 1621 Dartford Road,
Address: Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, bronchial — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days
DUE TO
(b) Myocardial infarction due to coronary occlusion
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ VA attended the deceased from December 31, 1929, to August 30, 1960 ~~that I last saw the deceased on the date stated above~~ and that death occurred at 1:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-30-60

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 8/31/1960
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR: DATE SEP 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9039 Item 1 FilmG269 8-25-60 et

Reg. Dist. No. 09024

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 44 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Milton Last: Smith

4. DATE OF DEATH Month: 8 Day: 19 Year: 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 6-12-1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retired~~ Theater Operator
10b. KIND OF BUSINESS OR INDUSTRY: Moving Pictures
11. BIRTHPLACE (State or foreign country): Paw Paw, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Clay Smith
14. MOTHER'S MAIDEN NAME: Sarah Frances Amos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-32-6539
17. INFORMANT: Mrs. John M. Smith, North East, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured skull with injury to Barin and
DUE TO (b) contusions of eyes and face and abrasion of knees
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

812X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trying to cross Route 40 and hit by truck
20c. TIME OF INJURY Hour: 8:30 a.m. p.m. Month, Day, Year: 8 17 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 40
20f. (City or town): North East (County): Cecil (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-19-60
EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Aug 19-1960
22c. NAME OF CEMETERY OR CREMATORY: Silverbrook
22d. LOCATION (City, town, or county) (State): Wilmington, New Castle Del
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant ADDRESS: North East Md
24a. REC'D BY REGISTRAR DATE: AUG 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9053 **CERTIFICATE OF DEATH** 09025

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 52 S. Carrollton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle H. Last STONE
4. DATE OF DEATH: Month August Day 19 Year 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-18-01
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steamfitter
10b. KIND OF BUSINESS OR INDUSTRY: Steamfitting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Halbert L. Stone (deceased)
14. MOTHER'S MAIDEN NAME: Daisy Brown (deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 219-07-4312
17. INFORMANT: Mary Stone, wife, Address: 52 S. Carrollton Avenue Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastasis to the liver — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
177X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 16, 1960, to August 19, 1960, and that death occurred at 5:25 a.m. from the causes and on the date stated above.

22a. SIGNATURE: J. L. Garey M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-19-60
22c. PHYSICIAN'S NAME (Type): J. L. GAREY
22d. ADDRESS: Clinical Pathologist, V.A. Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/60
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town, or county) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Harry H. Witzke, Baltimore, Maryland
25a. REC'D BY REGISTRAR DATE AUG 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9054 **CERTIFICATE OF DEATH** 09026

M 050

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 18 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 208 Mason Drive 15 X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAURICE — Middle R. — Last THOMAS
4. DATE OF DEATH: Month 8 — Day 27 — Year 1960
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-24-10
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Montgomery County, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES THOMAS (DECEASED)
14. MOTHER'S MAIDEN NAME: ESTELLE MILLS (DECEASED)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW-11
16. SOCIAL SECURITY NO.: 214-18-8237
17. INFORMANT: Mrs. Dorothy L. Carrol-Daughter — Address: 204 Martins Lane, Rockville, Md.

I

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: Approx. 2days

DUE TO (b) Carcinoma of the Pharynx with Metastasis to the Pericardium, pleura bilateral, and nodes — Unknown

DUE TO (c) of the Mediastinum.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

148X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 8-9-60, 19__, to 8-27, 1960, ~~XXXXXXXXXXXX~~ and that death occurred at 3:40 am from the causes and on the date stated above.

22a. SIGNATURE: J. L. Garey M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-27-60
22c. PHYSICIAN'S NAME (Type): J.L. GAREY, M.D.
22d. ADDRESS: VAH, PERRY POINT, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-31-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert Snowden — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: SEP 2 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9041

CERTIFICATE OF DEATH

09027
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST
c. LENGTH OF STAY IN 1b: 11 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LORA; Middle COLE; Last TYSON

4. DATE OF DEATH: Month AUG.; Day 17; Year 1960

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/5/1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): CECIL CO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN L. THOMPSON
14. MOTHER'S MAIDEN NAME: MARY R. WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: CARROLL TYSON
Address: NORTH EAST, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pelvic organs and Abdomen
DUE TO
(b) Ascites
DUE TO
(c) Cardiac Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 16, 19 59, to Aug 17/60, 1960, that I last saw the deceased alive on August 17, 1960, and that death occurred at 11.22 A. from the causes and on the date stated above.

ACTUAL SIGNATURE: H. A. Cantwell M.D.
ADDRESS (Street, city or town, state): North East, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): H.A. Cantwell M.D. North East, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/20/1960
22c. NAME OF CEMETERY OR CREMATORY: HOPE WELL CEM
22d. LOCATION (City, town, or county) (State): PORT DEPOSIT MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen
ADDRESS: RISING SUN, MD.
24a. REC'D BY REGISTRAR: DATE AUG 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9055

CERTIFICATE OF DEATH

09028

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point,
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS: Reynolds Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Woodrow; Middle: W.; Last: Vickery
4. DATE OF DEATH: Month: 8; Day: 4; Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-8-14
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Driver
10b. KIND OF BUSINESS OR INDUSTRY: Bus Company
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walton Vickery
14. MOTHER'S MAIDEN NAME: Parlee Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 256-03-7520
17. INFORMANT: Mrs Alton C. Vickery - wife — Address: Reynolds Ave Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.0
DUE TO
(b) Coronary thrombosis — 5 days
DUE TO
(c) Arteriosclerotic heart disease — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-1, 1960, to 8-4, 1960, that (I) (we) last saw the deceased alive on 8-4-1960, and that death occurred at 4:05P m. from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-8-60
22c. PHYSICIAN'S NAME (Type): ALBERT L. MOONEY, Asst. Pathologist
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 8/9/60
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town, or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE AUG 12 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9056 **CERTIFICATE OF DEATH** 09029

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md.
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 139 ThomasSt., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Preston; Middle; Last Watson
4. DATE OF DEATH: Month 8; Day 7; Year 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-29-92
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Not ascertainable
11. BIRTHPLACE (State or foreign country): Newland, Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gus Watson
14. MOTHER'S MAIDEN NAME: Lu Collier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Not ascertainable
17. INFORMANT: Thomas Watson (B) — Address: 139 Thomas St., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchial pneumonia, right lower lobe	4 days
DUE TO (b)	Carcinoma of the lung, right lower lobe.	Unknown
DUE TO (c)		

163

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized severe with arotic thrombosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 7-8, 1960, to 8-7, 1960, and that death occurred at 4:10 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Mooney, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ALBERT L. MOONEY, M.D., Asst. Pathologist VA Hospital, Perry Point, Md.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 8-11-60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON
23d. LOCATION (City, town, or county) (State): ARLINGTON VA.

24. FUNERAL DIRECTOR'S SIGNATURE: William E. Jones
ADDRESS: 1432 You ST. N.W.
25a. REC'D BY REGISTRAR DATE: AUG 17 '60
25b. REGISTRAR'S SIGNATURE: Clifford E. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9040

CERTIFICATE OF DEATH

09030
Reg. Dist. No.

(M)

065

1. PLACE OF DEATH
a. COUNTY: Cecil County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 369 W. Main St. Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 369 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Elbert — Last: Wiles
4. DATE OF DEATH: Month 8 / Day 22 / Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/13/1889
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): West Jefferson, N.C.
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Elbert Wiles
14. MOTHER'S MAIDEN NAME: Flora Sturgill
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 234-14-3555
INFORMANT: Florence Lowman — Address: Elkton, Md.

(I)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) CORONARY HEART DISEASE — 2-4 yrs
DUE TO
(c) ARTERIOSCLEROSIS

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumoconiosis, pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/21, 1960, to 8/22, 1960, that I last saw the deceased alive on 8/22, 1960, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter Stavrakis, M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 8/23/60

PHYSICIAN'S NAME (Type): Peter Stavrakis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-25-60
22c. NAME OF CEMETERY OR CREMATORY: Matt Mullins
22d. LOCATION (City, town, or county) (State): Beartown, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Pippin — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR: DATE AUG 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58